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Certificate of Need

Health Care Costs Compel Fresh Look at Old Regulatory Lever

By Michal Smith-Mello

An arcane, little-known regulatory lever, Kentucky's certificate of need (CON) process and the overarching health planning structure of which it is a part, have been in place for more than 30 years. Mandated by the federal government in 1974, CON was intended to help ensure a more rational development of the U.S. health care system, which underwent explosive growth in the years following federal enactment of need-based Medicaid, which is partly funded by states, and age-based Medicare.

Part of the federal Health Planning and Resources Development Act of 1974,¹ the law required states to develop local and state planning structures and implement review processes for additions or changes in the health care system based upon established criteria for public need. In theory, community-level planning backstopped by the state-level CON review and health planning process would prevent unnecessary duplication of services and the costs they were believed to inevitably add to the system. Arguably more important, the CON process also sought to ensure quality by limiting the location of sophisticated medical services, such as cardiac care, to regional facilities with proven expertise and experience.

Though the federal mandate has long since been repealed (1987), CON processes of varying scope remain in place in 36 states, including Kentucky. Given the most recent spike in health care costs, their effectiveness as a cost-containment tool and their relevance in today's era have compelled policymakers in some states to take a second look. Most recently, New Hampshire legislators defeated a bill that would have eliminated CON altogether, while Missouri permitted a large portion of its regulatory oversight to sunset after being targeted by a provider-led campaign to remove restrictions on hospital construction.

Here we examine the underlying cause for concern about CON's efficacy, the rationale behind it, the scope of its reach in states, arguments for and against it, and the strengths and weaknesses of Kentucky's process.

Ms. Smith-Mello is a Senior Policy Analyst with the Center.

Why Worry?

Rising spending for health care, many argue, is dampening the very fuel that stokes our economy, personal income and employer profits. Spiking health insurance costs—13.9 percent in 2003, the highest increase in 13 years²—are pushing health insurance out of the reach of more and more workers, their families, and small businesses while cutting deeply into employer profits, affecting hiring, job retention, and benefits for both current workers and retirees. At both the federal and state levels, scarce government resources that might otherwise go to solve critical public problems are arguably being displaced by increased spending for health care.

While maintaining public health is vital to our economy and a societal good worthy of resources, many view the doubling of national health care expenditures as a percent of the gross domestic product

since 1970, from 7 percent to 14.9 percent in 2002,³ as a dilution of American productivity and strength. Alternatively, others argue that health care is vitally important to our economy, sustaining and enabling higher rates of productivity for all workers, creating high-quality jobs, spawning entrepreneurs and important product innovations, and, in the process, achieving perhaps the ultimate public good—saving lives, improving quality of life, and preserving the productive capacity of citizens.⁴

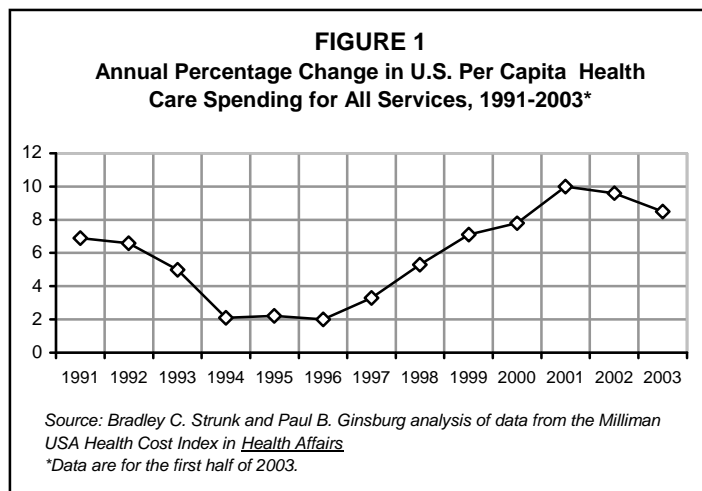
Several factors are pushing health care spending levels higher: rising rates of utilization, a measure of the frequency of our use of health care services *and* changes in the mix of these services;⁵ increasing costs after a decade during which the health care cost index declined under the bargaining pressure of managed care; and “aggressive copycat behavior and one-upmanship” in what some health researchers see as a surging medical arms race.⁶ Recent data, however, show that, after rising for five consecutive years, the rate of increase in per capita health care spending slowed from a peak of 10 percent in 2001⁷ to 8.5 percent during the first half of 2003⁸ (see Figure 1). While important, it remains well above the 2 percent and 3 percent rates of increase that managed care achieved in the mid-1990s by restraining patient utilization.



Recently, utilization rates have played a prominent role in health care expenditures, rising from an average annual rate of 1.6 percent between 1993 and 2000 to 3.8 percent per capita in 2001.⁹ Several factors are influencing utilization. Patient and provider rejection and legislative responses to public disaffection have loosened the reins of managed care imposed by private insurers. Dramatic advances in the prevention, diagnosis, and treatment of disease and illness combined with aggressive marketing and advertising clearly also have whetted the public appetite for health care. Advertising alone has been shown to influence patient demands as well as physician decisionmaking.¹⁰ Readily available and increasingly sophisticated health information via the Internet is also affecting utilization to an unknown extent.

During this latest cycle of rising expenditures, it appears that utilization rates are being checked not by insurers but by employers, who have cut benefits and shifted more of the cost of health insurance to their employees, current and retired, and thus discouraged use. In addition to shrinking benefit packages for new hires, more and more companies are eliminating health coverage for retirees or requiring them to pay for it.¹¹ In turn, health care benefits—not wages—have become the pivotal issue in recent labor disputes. But more of the same lies ahead: survey data show that about half the nation's employers plan to shift more costs to employees in the coming year.¹² As a consequence, the central vehicle for providing health insurance through employers appears less and less roadworthy.

Americans see reason for alarm. In a March 2004 poll, Gallup found that health care provoked the most worry among Americans, with 62 percent saying that they worry "a great deal" about both the availability and the affordability of health care.¹³ A substan-



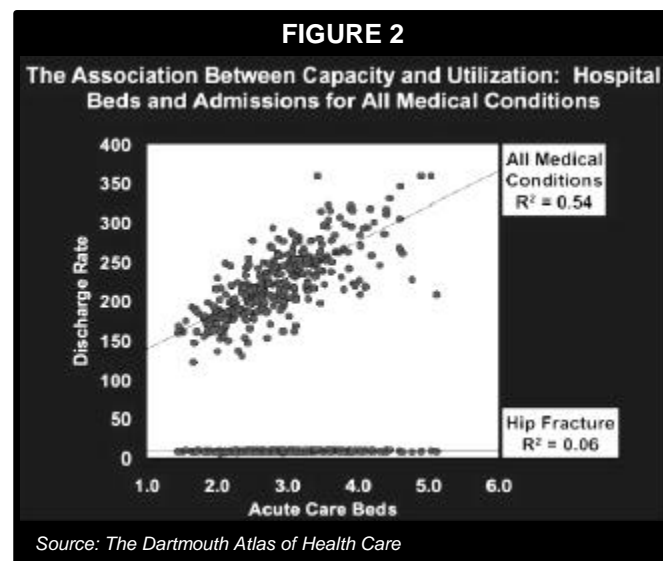
tially smaller percentage of respondents cited other sources of great concern, including crime and violence (46 percent), drug use (46 percent), terrorism (42 percent), and the economy (41 percent).¹⁴

What's CON Got To Do With It?

The certificate of need process could be likened to managed care for providers, a gateway through which they must pass in order "to acquire, establish, offer, or substantially change a health service."¹⁵ Just as private insurers sought to discourage would-be patients from unnecessary use of health services, CON ostensibly discourages the unnecessary creation of health services and the spending for them that is believed to inevitably follow.

The rationale behind CON's restraints is based upon the longstanding assumption that the supply of health care services induces demand. The late public health pioneer, Milton E. Roemer, first advanced the idea around 1960 and reiterated it in 1993, "If there is an assured payment system, it seems that almost any additional hospital beds provided will tend to be used, up to a ceiling not yet determined."¹⁶ While we clearly do not use the hospital beds we have—utilization of acute care beds stood at less than 50 percent here in Kentucky in 2002¹⁷—few question that we pay for them.

The *Dartmouth Atlas of Health Care* offers perhaps the most comprehensive analysis of the "supply sensitive" nature of many



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KENTUCKY

LONG-TERM POLICY RESEARCH CENTER
111 St. James Court, Frankfort, Kentucky 40601-8486
Phone: 502-564-2851 or 800-853-2851
Fax: 502-564-1412 or 800-383-1412
E-mail: info@kltprc.net
www.kltprc.net

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health care services. In its ongoing examination of health care spending levels for Medicare enrollees in U.S. hospital referral regions (HRRs), the *Atlas* finds as much as a twofold difference that cannot be attributed to differences in prices, rates of illness, nor socioeconomic status.¹⁸ Instead, these researchers conclude that the frequency of visits to certain specialists, the number of admissions and the length of hospital stays, and the performance of elective surgical procedures and diagnostic tests are consistently associated with *the supply* of these services.¹⁹ Regional differences in Medicare spending, they conclude, are largely attributable to the patterns of practice found in high-spending regions, which emphasize inpatient treatment and specialist-oriented care.²⁰

For example, as illustrated in Figure 2, Dartmouth researchers compared 1996 rates of hospitalization for Medicare enrollees in the nation's 306 HRRs for hip fracture, for which hospitalization is clearly established best practice, to admissions for all medical conditions. As shown, the rate of hospitalization (discharge rate) for all medical conditions increases with the supply of acute care hospital beds while the rate of hospitalization for hip fracture remains virtually constant regardless of supply. In short, these researchers observe, "capacity matters."²¹ That is, the greater the availability of certain health care services, in this case hospital beds, the higher the rate of utilization. And, as recent cost spikes have shown, utilization has a dramatic impact on how much we spend on health care.

TABLE 1 Acute Care Hospital Beds per 1,000 Population, Kentucky, U.S., 1996	
Hospital Referral Region	Beds per 1,000
Paducah	3.6
Lexington	3.5
Louisville	3.1
Owensboro	2.9
Covington	2.5
U.S. Average	2.8
Source: Dartmouth Atlas of Health Care	

Not surprisingly, capacity also matters in Kentucky, the *Dartmouth Atlas* shows. The number of acute care beds per 1,000 residents exceeds the national average (2.8) in 4 of the state's 5 HRRs. Only in the Covington HRR does capacity trail the national average and only slightly while, as shown in Table 1, the supply is greater in the state's remaining HRRs.²² The *Dartmouth Atlas* also shows that 1996 rates of hospital discharges for all medical conditions per 1,000 Kentucky Medicare enrollees ranged between 268 in Louisville and 314.4 in Lexington, compared with a national range of 121.9 to 359.8.²³

Health planners offer caveats to Kentucky's seeming glut of hospital beds, only 45 percent of which are currently being utilized.²⁴ On one level, the "franchise" hospitals have on allotments of beds masks the real scope of need; on another, most hospitals lack the staff to utilize the bed capacity for which they are licensed, complicating the process of planning responses to potential public health emergencies, such as a bioterrorism attack or an epidemic.

Importantly for future planners, the architects of the *Dartmouth Atlas of Health Care* and other researchers conclude that more health care is not necessarily better health care. Neither quality of care, access to care, health outcomes, nor satisfaction with care were found to be better in higher-spending regions.²⁵

A related 2003 study also confirms the link between the supply of new technology and increased utilization but questions whether simply limiting supply will reduce spending.²⁶ Instead, the authors suggest, the association between technology availability and spending may be attributable to other factors, such as the presence of populations with greater need, a factor Dartmouth researchers control for, or higher technology costs as a means of compensating "upstream" innovations,²⁷ the argument used by pharmaceutical firms to justify high U.S. drug costs. Ultimately, the authors suggest, health care technology must be evaluated in terms of its cost *and* its benefit to society, and limitations on its diffusion designed accordingly,²⁸ an argument for greater attention to quality that is gaining ground.

Current Status

Since their inception, state-level CON processes have evolved in response to the larger regulatory environment, new cost drivers, and changes in medical practice. Today, 36 states and the District of Columbia retain at least some vestige of the CON process on the longstanding assumption that by controlling supply they can contain consumer demand and restrain health care spending. Even the 14 states that have jettisoned the CON process have retained health planning, policy, or regulatory entities.²⁹

CON review processes vary widely by state in their decisionmaking structure, the scope of services subjected to regulatory scrutiny—from the conversion or addition of acute care beds in hospitals to purchases of ultrasound equipment—and the spending threshold that triggers review of capital expenditures, purchases of new equipment, or the development of new services. Long-term care is a consistent focus. In *every* state with a CON review process, any addition of or change in long-term care beds, 70 percent of which are reimbursed by partly state-funded Medicaid, is subject to review. Moreover, additions of acute care hospital beds and ambulatory surgery centers, as well as psychiatric, open-heart surgery, cardiac catheterization, and rehabilitation services, are subject to review in most, but not all, of the 23 states with the broadest regulatory frameworks.

Annually, the American Health Planning Association (AHPA) publishes a directory of health planning, policy, and regulatory agencies, ranking CON states by a formula (number of services reviewed X a weight assigned to the spending threshold). As shown in Table 2, those states ranked highest subject new health services to the most intensive regulatory scrutiny. In 2003, CON states essentially fell into three categories based upon the assigned weight of the regulatory structure, with the combined scope and threshold in the upper tier ranking between 21 and a possible but remote 40 and the lower tier ranking below 10.

While Kentucky regulates 18 of the 29 services AHPA monitors plus mobile units, its cost threshold is set at a relatively high level (\$1,831,594 for both capital expenditures and medical equipment purchases). As the state's threshold for review has risen, its actual ranking among CON states has fallen from 13th to 18th, or, based upon the AHPA scale, from 16.2 in 2000 to 14.4 in 2003.

Most states without CON processes are in the Midwest and the West and number among the nation's most rural, making any growth in the health care industry a welcome addition for many. Encouraging growth also may be in the best interest of citizens when a large older population is present. In fast-growing, CON-free Arizona, a

TABLE 2
2003 Rankings of States with CON Reviews,
Based on Scope of Regulated Services
and Cost Thresholds for Review

State	Rank*	Number of Services	Weight of Threshold
Maine	31.2	24	1.3
Connecticut	28.8	24	1.2
Alaska	26.0	26	1.0
Vermont	21.6	24	0.9
South Carolina	20.9	19	1.1
Georgia	20.9	19	0.9
West Virginia	20.7	23	0.8
North Carolina	18.4	23	0.8
Tennessee	17.6	22	0.8
Mississippi	17.0	17	1.0
Alabama	16.8	21	0.8
Rhode Island	15.2	19	0.8
New York	15.0	25	0.6
Hawaii	15.0	25	0.6
Maryland	14.4	16	0.9
Michigan	14.4	18	0.8
Kentucky	14.4	18	0.8
Illinois	13.3	19	0.7
Washington	12.8	16	0.8
New Hampshire	12.6	14	0.9
New Jersey	12.1	11	1.1
Missouri	10.4	13	0.8
Iowa	8.1	9	0.9
Virginia	8.0	20	0.4
Florida	7.7	11	0.7
Oklahoma	7.0	5	1.4
Montana	6.3	7	0.9
Arkansas	6.0	5	1.2
Massachusetts	4.8	16	0.3
Delaware	4.8	8	0.6
Wisconsin	4.4	4	1.1
Nevada	3.5	7	0.5
Nebraska	3.0	2	1.5
Oregon	2.4	2	1.2
Ohio	0.5	1	0.5
Louisiana	0.4	2	0.2

Source: American Health Planning Association

retirement haven for millions of Americans, hospitals are experiencing capacity problems.³⁰ Similarly, in Miami, Florida, another premier retirement haven where CON processes are still in force but relatively weak, hospital capacity is being strained, not by obstacles to construction and expansion, but as a result of labor shortages and increases in admissions,³¹ a trend being seen in many cities and states, including our own.

Thus, insufficient hospital capacity is emerging as a problem in states with high older populations, a group that many demographers predict Kentucky will soon number among. But the community studies of the Center for Studying Health System Change (CSHSC) suggest that the presence or absence of CON may not be the decisive factor in avoiding these problems. Instead, la-

bor—or the lack of it—appears to be a national problem for hospitals that is pushing costs upward and affecting services.

In recent years, some states have or have attempted to jettison the CON process or large portions of it, and their experiences, while relatively new and not comprehensive in many cases, offer some lessons. Still other states have repealed the CON process only to re-enact it when growth in a particular component of health care, usually long-term care beds, surged.

At Issue

On the face of it, the question of whether to eliminate, strengthen, or maintain the status quo of the CON process pits government regulation against a free market approach. Rather than a simple black or white issue, however, the issues surrounding CON lie in an uncertain gray area.

Proponents of eliminating the CON process altogether argue that the process has always been tainted by political interference and that, over the long run, competition will encourage more entrepreneurial approaches to health care and ultimately provide consumers with lower-cost options, producing winners as well as losers among providers. Supporters of the CON process see consumers as the ultimate losers, who will pay the price of unfettered competition among providers, the increased demand it stimulates, and the higher costs that result. They also argue that general, not-for-profit hospitals and the recipients of charity care from these institutions will be likely losers in a competitive environment. Federal law requires hospitals to screen and stabilize all patients, regardless of their insured status, and prohibits transferring them. Without hospitals, asks Nancy Galvagni of the Kentucky Hospital Association, which supports retaining the existing review requirements of CON, “Who will pay for this care?”

But even with CON laws firmly in place, competition between physicians and hospitals in states with and without CON processes is red hot. Kentucky is no exception. Physicians are creating or becoming partners in diagnostic facilities, ambulatory care/surgery centers, and, in a handful of states, for-profit specialty hospitals. Aimed at patients who can afford them, often located in affluent suburban communities, and focused on profit centers such as cardiac care, which can account for as much as 35 percent or more of community hospital revenue,³² specialty hospitals effectively siphon some of the most profitable services away from general hospitals. Likewise, ambulatory surgery centers have had a measurable effect on the volume of hospital services. Gradually, the capacity of “generals” to maintain critical and often costly services and cross-subsidize less profitable basic services like emergency departments is undermined. As a result, some central city and rural hospitals have seen revenues decline or closed altogether.

The growth of enterprises in which doctors have a stake is attributed to entrepreneurial efforts to replace lost income. Between 1995 and 1999, physician income dropped by 5 percent nationally. Since 2000, Medicare rate reductions, Medicaid cost-containment efforts prompted by state fiscal crises, rising malpractice insurance rates, and the impact of rising costs on maintaining a practice have continued to cut into physician income.³³ In 12 markets where CSHSC researchers conducted a recent round of community-tracking studies, interviewing 270 medical professionals, increased physician investment in ancillary services, from laboratory to imaging equipment, was reported as a practice strategy to increase patient volume and income. In all but one market, physi-

cians were reported to be developing specialty facilities that provide a range of services, including diagnostic tests. In 10 markets, physicians reportedly have dropped Medicare and/or Medicaid patients as a practice strategy to limit risk and low margins.³⁴ Cumulatively, these researchers conclude that the physician strategies found in these diverse communities threaten to raise costs by inducing demand for services, a trend they suggest policymakers may want to counter by taking “a more active, compensatory role.”³⁵

In spite of its presence in the active CON category, Kentucky has essentially adopted a hands-off approach to physician practices, which have grown significantly even during the recent economic downturn. CON’s role is one that the Kentucky Medical Association (KMA) expressly does not wish to see change. KMA spokespersons declined to be interviewed for this article offering instead a written summary of KMA’s April 1997 position on CON, when its Board of Trustees went on record in support of preserving “the private physician’s office exemption” from CON, with the exception of review for expenditures of \$250,000.

From specialty hospitals to rapidly growing physician practices, patients, key medical personnel, and health care dollars are gradually moving away from traditional hospitals to smaller, more focused enterprises. In the process, the charity care our health care system metes out, as well as jobs and community institutions, could be lost in the process. While the diffusion of services that were once concentrated in hospitals may represent a natural evolution of market-based health care, it also poses a threat to the viability of community and teaching hospitals. The possible consequences have gotten the attentions of the Federal Trade Commission and the Antitrust Division of the Department of Justice, which began holding hearings last year on the role of competition in the health care industry, consumer and antitrust protection, and cost-effective

care. These concerns also figured in the inclusion of an 18-month moratorium on new hospital construction in the 2003 federal Medicare legislation.³⁶

The role of CON could be central to whether we encourage or contain competition among providers and its seemingly inevitable outcome, supply-induced demand. In the case of specialty hospitals, the GAO found that 96 percent had been built since 1990 and in states that no longer require state approval—a certificate of need—to increase hospital bed capacity.³⁷ And while specialty hospitals were found in 28 states, about two thirds of them are in seven states, five of which completely eliminated their certificate of need processes in 1986 and 1988 (Arizona, California, Kansas, South Dakota, and Texas).³⁸

One 1997 study, however, found no evidence of a surge in acquisitions of hospitals or costs after the lifting of CON regulations.³⁹ This same study also found that mature CON programs resulted in a slight reduction in bed supply (2 percent) but higher per-day and per-admission costs. Mature CON programs were, it found, associated with a modest reduction (5 percent) in spending for acute care beds but not in overall expenditures.⁴⁰ Indeed, the

study suggests that CON plays a role in preserving the status quo, the market dominance of a select group of hospitals.

Ohio’s experience, however, suggests that some of the fears about eliminating CON may be justified. Subsequent to its repeal of CON review except for long-term care beds, the number of hospitals and hospital beds has declined, while the number of ambulatory surgery centers and diagnostic imaging centers has risen sharply.⁴¹ Hospital beds have been lost mostly in urban centers, where 11 hospitals closed between May 1997 when deregulation went into effect and December 2000.⁴² Another 6 hospitals closed in mid-sized communities and 4 in rural areas. Overall, with the exception of an increase in long-term care units within hospitals, a potentially worthy strategy for tapping unused capacity, the state experienced a net loss of 23 hospitals and 4,577 beds.⁴³ In Cleveland, where two hospitals closed after deregulation, emergency rooms have seen patient loads rise sharply and, for a time, diversions to other hospitals created significant problems.⁴⁴ In response, Ohio has imposed a moratorium on specialty hospitals, and some hospitals are ending the privileges of physicians who refer patients to the specialty hospitals in which they have invested.⁴⁵

Similarly heated competition between general and specialty hospitals has been found in Indiana, which ended its CON process in 1998. In its community report on Indianapolis, the CSHSC concluded that, because no brakes could be applied to the all-out competition it found in there, “employers have little leverage with health care providers; health plans seem resigned to passing on providers’ demands for higher payments; and state policymakers have few tools to influence expansion decisions, having long ago repealed certificate of need laws.”⁴⁶

In Michigan, which is home to a mature and stringent CON process, hospital capacity is strained, but largely due to labor shortages and a shortage of diagnostic equipment.⁴⁷ Here, strong support for CON has issued from the nation’s big three automakers, still dominant Michigan employers.

Their studies of the per-covered-employee costs they pay in states with and without CON processes have found variances ranging from \$3,519 per person in CON-free Wisconsin to \$1,331 in New York,⁴⁸ home of the nation’s oldest CON process.⁴⁹ Of interest to Kentuckians, Ford Motor Company found that it pays less for both inpatient and outpatient services in the CON states where it has operations—Kentucky, Michigan, and Missouri. Indiana’s costs were about 13 percent higher while largely deregulated Ohio’s costs were about 7 percent higher for inpatient services than Kentucky’s; both states were 21 percent higher for fast-growing outpatient services.⁵⁰

While these findings are telling, scant research exists to show that CON programs have held costs in check or even reduced the supply of hospital beds. Other factors, most notably the penetration of managed care, appear to be far more effective, if widely mistrusted and rejected, cost-containment levers. Indeed, the recent arrival of health care at 15 percent of gross domestic product is, by Princeton health economist Uwe E. Reinhardt’s estimation, “what the American people asked for when they abolished managed care.”⁵¹



On the other hand, research links CON programs to higher quality care, which some argue is a far more important focus and ultimately the key to lower costs. In a study of the administrative records of Medicare beneficiaries, Iowa researchers found that the risk of death for those receiving coronary artery bypass graft (CABG) surgery was 21 percent higher in states with no CON regulation compared to states with continuous regulation between 1994 and 1999.⁵² Thus, many fear that eliminating CON altogether will only further escalate the “medical arms race,” undermine accessibility to health care, and, in the absence of a counterbalancing lever, erode quality.

Because many fear the effects of eliminating CON, it will be important to monitor changes in Missouri, which opted not to reauthorize much of its CON program in 2001.⁵³ While experiences such as these could offer important and instructive guidance, the very health planners who might assess the consequences of such legislative actions and propose appropriate responses have tended to disappear along with the CON regulatory structure.

Devolution and Dissolution

By all accounts, Kentucky’s CON process, which predated the federal mandate, began as a highly participatory, community-driven health planning process. Over the years, however, it has undergone change with virtually each gubernatorial administration, devolving into a fragmented, highly centralized administrative process that one long-time observer characterizes as “essentially a provider-led dialogue” from which consumers, taxpayers, and even health policy analysts are essentially excluded.

Today, in place of a decisionmaking entity with grounding in health policy, CON decisions are made by administrative hearing officers who do not necessarily possess expertise in health care. Hearings are open to the public, but public awareness of them and the potential import of decisions made to communities is limited to key players. What’s more, rather than the flexibility to meet need as it arises, decisions are products of formulae outlined in the state health plan, rather than an identified community need that arises from the local level. By one long-time observer’s estimation, health care in Kentucky is strongly influenced by a cadre of attorneys who appear before attorney/hearing officers on a routine basis.

For the state’s largest providers—and their consumers—it is a costly, often adversarial process that can give rise to legal battles between providers intent on blocking one another’s expansionist urges as well as advancing one’s own. For small providers who want to launch or expand services, such as home health care or Hospice services or facilities, the process virtually demands legal representation, which, combined with the \$250 application fee, can be cost prohibitive for some. The process, by its own director’s assessment, “chokes on gnats and swallows camels whole.”

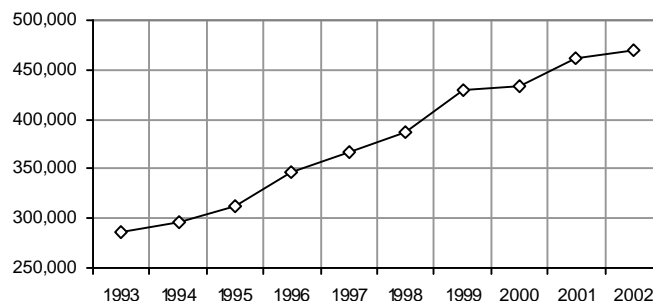
At the same time, health planning has become essentially a *pro forma* process that no longer responds to public need, largely because the community-based element of the process has been abolished. During the 1990s, as managed care reached its apex, it was widely believed that comprehensive health care planning was no longer needed. On that assumption, the remarkably high levels of civic engagement in health care planning that Kentucky once enjoyed ended unceremoniously. Ironically, it is just such engagement—consumer awareness of health care costs—that many current policymakers see as key to raising public awareness of health care costs.

Today, the state health plan serves primarily as a blueprint for what Medicaid will or will not reimburse. When Medicaid expenditures for a particular type of health service rise, the plan effectively blocks this route to expansion or, as in recent years, blocks all expansion when Medicaid expenditures exceed budgetary capacity. But as Galvagni observes, “You plug one hole, and it’s going to come out somewhere else.”

With all needs standards removed from the state plan, the only avenue left for growth has become physicians’ offices, which are exempt from CON review in Kentucky and most states. In effect, Galvagni argues, the state plan is “legitimizing” the performance of diagnostic tests, surgeries, and other health services in physicians’ offices to the detriment of hospitals.⁵⁴ One of the changing dynamics of health care delivery here and throughout the nation can be seen in the shift to outpatient surgery and services, but evidence suggests that smaller, some privately held, physician-owned facilities are drawing a significant number of patients and profits away from hospitals.

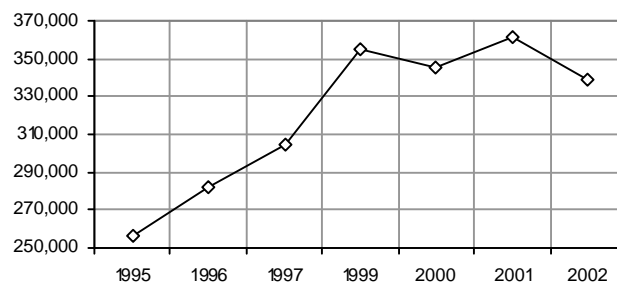
As shown in Figure 3, the number of outpatient or ambulatory surgeries performed in ambulatory surgery centers has grown steadily in Kentucky while those performed in the surgical facilities of hospitals (Figure 4) have recently declined. Between 2001 and 2002, 22,330 fewer “ambulatory operations” were performed in Kentucky hospitals. Thus, hospitals are losing more of the services that usually represent a profit center. Over the long term, their viability could be jeopardized.

FIGURE 3
Surgical Procedures Conducted in Kentucky
Ambulatory Surgery Centers, 1993-2002



Source: Health Policy Branch, Kentucky Department for Public Health

FIGURE 4
Ambulatory Surgery Procedures Conducted
in Kentucky Hospitals, Selected Years



Source: Health Policy Branch, Kentucky Department for Public Health

Kentucky's CON process has another noteworthy gap: a \$1.83 million cost threshold for review of both capital expenditures and equipment purchases. The latter is the third highest reported among CON-regulated states. Michigan, which is given the same rank as Kentucky on AHPA's scale, subjects *all* equipment purchases to review.⁵⁵ When it comes to health care hardware, Gray observes, "You can buy almost anything for under \$1.8 million."

Further, once a purchase or an expansion becomes licensed, the CON process has no mechanism for ensuring that the cost presented in applications is indeed the actual cost of a project. CON Director John Gray describes it as a providers' get-out-of-jail ticket. "Once a facility is licensed, they can do whatever they want," observed Gray.⁵⁶ And, as a recent investigation by *The Courier-Journal* showed, providers are routinely sidestepping required CON review of equipment purchases altogether,⁵⁷ something a tiny agency with few resources can do little about. Indeed, one business plan aimed at would-be physician investors in Louisville details its strategy for avoiding the \$1.8 million trigger of CON review: "Since this amount applies to the aggregate, three separate deals will be structured."⁵⁸

Yet another potential problem can be seen in the current approach to long-term care. Demand for this service will almost certainly rise sharply in coming years as Baby Boomers age; however, the state health plan has stymied growth of long-term care beds in nursing facilities, which are reimbursed largely by cash-strapped Medicaid. No new nursing care beds were approved in 1998, 2000, or 2001,⁵⁹ and complete moratoria on them have been imposed repeatedly. State-wide, the average occupancy rate for nursing beds in 2002 was 91.1 percent, down from 95 percent in 1995,⁶⁰ a positive utilization trend but one that does not necessarily reflect preparedness for the future.

While the state health plan has held nursing home development in check, assisted living, a rapidly growing if ill-defined facet of elder care, is being permitted to grow without restraint in Kentucky and other states in anticipation of future needs for an array of care levels for elders. Some state health planners believe that the recent reductions in nursing home occupancy are likely the result of more people opting for assisted-living facilities, rather than declining utilization. Too, the absence of regulatory scrutiny is an incentive for developers to build assisted-living facilities when construction of traditional long-term beds are blocked. But because Kentucky's Medicaid Program, which pays for about 70 percent of nursing home care in Kentucky but, unlike 41 other states, does not reimburse residential or assisted-living care,⁶¹ health planners see our system moving toward assisted living as an expensive, amenity-rich, private-pay option, when the lower levels of care it offers elders could be a less expensive option resulting in potential Medicaid savings.

In spite of its widely acknowledged flaws, Kentucky would find itself in rare company without CON. Few states have been willing to jettison the process altogether and let the health care market determine winners and losers.

An Unplanned Future

Planning to meet future public health needs, many analysts assert, is essential if we are to improve the state's and the nation's health care system. Improved quality, what many analysts argue is the only path to stable costs, depends upon it. Here in Kentucky, we collect substantial health data, and our small cadre of health planners reports some of it, but the staff lacks the resources to systematically analyze these data for implications about the future and report them to an audience with the authority to effect needed change.

A case in point can be seen in the rise of "psychoses" as the diagnosis related group (DRG) of record upon hospital discharge. In this case, psychoses refers to a range of mental illnesses. In 2002, "psychoses" was the DRG for nearly 20,000 hospitalizations in Kentucky, ranking 4th out of the 26 possible DRGs for hospital discharges, behind only the broad "all other," normal newborns, and childbirth without complications.⁶² In 2001, psychoses ranked 7th.⁶³ On average, patients who were discharged under a "psychoses" DRG were relatively young, 39.5 years old in 2002, compared to a significantly higher average age for virtually every DRG except newborns, their mothers, and children with asthma or bronchitis.⁶⁴ What's more, the length of stay averaged 8.5 days compared with the average of 5.0 days for all discharges and was exceeded only by the "rehabilitation" DRG in which victims of severely incapacitating illnesses such as strokes are classified.⁶⁵ In two Area Development Districts psychoses was the second leading DRG in 2002.⁶⁶

What has this seemingly disturbing development meant for health planning in Kentucky? Are we investing more on the front end in our mental health centers and enabling access to the medication and treatment needed to prevent chronic, severe, and disabling mental illnesses and the medical crises they precipitate when left untreated? By most assessments, we are not. Our network of mental health centers reportedly faces critical staff shortages and chronic difficulties with recruiting due to low salaries. Further, in July 2003, a presidential commission described our national system of mental health care as a "patchwork relic" of federal and state facilities that often block rather than enable care.⁶⁷

The state's small cadre of health planners also sees the need to become more flexible to adapt to medical breakthroughs. Recent medical literature, for example, concludes that the standard protocol for treating a heart attack victim with "clot-busting" drugs should be revised immediately in favor of emergency angioplasty, which effectively stops a heart attack and the debilitating damage it does to heart muscle. One study found that the time lapsed after a heart attack for those who were transferred to a hospital with a cardiac surgery unit for emergency angioplasty was double that for those who received it immediately, and death rates were one third higher for patients who were transferred to another hospital rather than receiving emergency angioplasty on site, regardless of the hospital's cardiac surgery capacity.⁶⁸ In the past, angioplasties have been limited to hospitals with cardiac surgery units, which are costly to create and staff, but some hospitals in the state have trained staff



but do not have the licensed facilities. Governor Fletcher's administration reportedly plans to respond by adopting KHA proposals for a multi-year study in two to three hospitals to learn if this procedure can be performed safely in facilities without onsite open heart surgery units.⁶⁹

Such advances in science, which are emerging at an accelerating pace, strongly suggest the need for a regulatory structure that is more nimble and responsive to evidence-based protocols that can save lives and restore productivity, and, in the process, perhaps extend greater benefits to society.

Conclusion

In sum, few voice confidence in what has become of health planning and the CON process in Kentucky. Hospitals and their representatives and advocates for the poor see it as a flawed but necessary bulwark against further erosion of hospital viability, charity care, and an already weakened rural provider network. Evidence from other states and research suggest their concerns are not without justification. Critics, who include its practitioners, old and new, see our current bare bones approach to CON and health planning as relatively ineffectual, costly to the overall system, inflexible, and often irrational. What's more, they believe CON inhibits, even prohibits, the entry of providers who could benefit citizens of the Commonwealth. That health care expenditures continue to rise, needs remain unmet, and the system remains rife with problems, proponents and opponents would likely agree, should come as no surprise. Regardless of the perspective, the question of how to fix what is broken yields no easy answers.

Clearly, real health care planning, which has fallen by the wayside in most states, even those with CON processes, is needed to respond to the changing dynamics of health care, including the explosion of medical technology and its many implications for health care delivery, the demands of an aging population, and rising levels of in- and outpatient hospital utilization.⁷⁰ Further, if the influence of managed care continues to wane under pressure from patients and providers, the rationale for our virtual abandonment of comprehensive planning with community-level input, however flawed the assumption was, will have been removed. Arguably, comprehensive health care planning may be needed now more than ever. For the foreseeable future, however, the Fletcher administration is not expected to make dramatic changes to CON. It will reportedly keep the moratorium on new construction in place, sanction limited experimentation with angioplasties outside cardiac surgery units, and move to "level the playing field" for hospitals, particularly in rural areas, through regulatory changes in Chapter 216B.015 of the Kentucky Revised Statutes.

Other possible avenues for change can be found in the work of national private and public sector initiatives focused, as CON is in part, on ensuring higher quality health care in the United States, the neglect of which, some studies suggest, comes at a very high cost. Significant evidence of costly medical errors and outcomes

is being documented by a growing body of research. For example, a year-long study of Medicare patients in the care of a multi-specialty practice concluded that adverse drug effects among older patients were common and often preventable.⁷¹ Similarly, a 2001 study concluded that medication errors among hospitalized children were common.⁷² More recently, a 2003 study found that hospital medical injuries vary in their level of severity, but, at their worst, they increase the length of hospital stays, add significant costs, and increase mortality.⁷³

Today, a legion of medical professionals, researchers, and businesses that are paying the price for health care have become proponents of medical practices designed to ensure higher quality. Among other things, they advocate widespread adoption of evidence-based care, grounded in the proven efficacy of certain treatment protocols, prescription drugs, diagnostic tests, and surgical procedures; computerized communications to help prevent medication and other treatment errors; consumer and public health education campaigns; and readily available and accessible data about hospital and physician performance. The Business Roundtable's Leapfrog Group, an organization of 150 public and private providers of health care benefits, has developed purchasing strategies, rewards and incentives for quality, and consumer education efforts, all aimed at reducing medical errors.⁷⁴ On a grander scale, the

national Institute of Medicine's report, *Crossing the Quality Chasm: A New Health System for the 21st Century*, sets ambitious performance standards for the nation's health care system, recommending rules to guide patient-clinician relationships, an organizing framework to help align the incentives inherent in payment and accountability with improvements in quality, and steps to promote evidence-based practice and strengthen clinical information systems.⁷⁵

The evidence suggests that broad adoption of "best practice" standards, which is already underway in many hospitals and physician practices, could not only improve quality of care and patient outcomes but also reduce unnecessary expenditures. Ultimately, these new approaches to health care may not cost less, but, then again, the dramatic disparities we see in spending between regions and states combined with the documented costs of medical errors suggest *they just might*.

Timely and comprehensive health care planning combined with thoughtful and flexible regulations arguably could play an important role in the diffusion and institutionalization of new standards of care among providers and in the education of citizens. Moreover, revitalization of the vibrant civic capacity that once defined health planning in Kentucky could help forge a new vision of health care in our state. But such a role for planning would require new investment and no doubt inspire the resistance of many who profit from the status quo. Both will likely prove to be formidable obstacles to the development of a more rational approach to health care, which will demand the cooperation and collaboration of all parties, something that appears to be sorely missing from the present health care arena. ☐

... health planners see our system moving toward assisted living as an expensive, amenity-rich, private-pay option, when the lower levels of care it offers elders could be a less expensive option resulting in potential Medicaid savings.

Notes

- ¹ Bradley C. Strunk and Paul B. Ginsburg, "Tracking Health Care Costs: Trends Slow in First Half of 2003," *Data Bulletin No. 26*, Center for Studying Health System Change (CSHSC), Dec. 2003 <www.hschange.com/CONTENT/633/?PRINT=1>, 12 Dec. 2003.
- ² Strunk and Ginsburg.
- ³ Katharine Levit, Cynthia Smith, Cathy Cowan, Helen Lazenby, Art Sensenig, and Aaron Catlin, "Health Spending Rebound Continues in 2002," *Health Affairs* 23.1 (2004): 147.
- ⁴ See, for example, Charles R. Morris, "Health Spending Is Soaring. What's So Bad About That?" *Medical Economics* 6 March 2000, and Theodore Roszak, *America the Wise* (New York: Houghton Mifflin, 1998).
- ⁵ Katharine Levit, Cynthia Smith, Cathy Cowan, Helen Lazenby, Art Sensenig, and Aaron Catlin, "Trends in U.S. Health Care Spending in 2001," *Health Affairs* 22.1 (2003): 155.
- ⁶ Cara S. Lesser and Paul B. Ginsburg, "Health Care Cost and Access: Problems Intensify," (CSHSC) *Issue Brief* 63 (May 2003).
- ⁷ CSHSC, "Tracking Health Care Costs: Trends Stabilize but Remain High in 2002," *Data Bulletin No. 25*, June 2003.
- ⁸ Strunk and Ginsburg.
- ⁹ Katharine Levit, Cynthia Smith, Cathy Cowan, Helen Lazenby, Art Sensenig, and Aaron Catlin, "Health Care Rebound Continues in 2002," *Health Affairs* 22.1 (2003): 148.
- ¹⁰ Richard L. Kravitz, Robert A. Bell, Rahman Azari, Steven Kelly-Reif, Edward Krupat, and David H. Thom, "Direct Observation of Requests for Clinical Services: What Do Patients Want and Do They Get It?" *Archives of Internal Medicine* 163 (2003): 1673-1681.
- ¹¹ Milt Freudenheim, "Companies Limit Health Coverage of Many Retirees," *The New York Times* 3 Feb. 2004, <www.nytimes.com> 3 Feb. 2004.
- ¹² Vanessa Fuhrmans, "Shifting Burden Helps Employers Cut Health Costs," *The Wall Street Journal* 8 Dec. 2003: B1.
- ¹³ Gallup News Service, "Healthcare Heads List of Americans' Worries," *Gallup Poll Tuesday Briefing*, online subscription service, 30 March 2004.
- ¹⁴ Gallup.
- ¹⁵ Eric T. Clark, "Certificate of Need," in *Issues Confronting the 2003 General Assembly*, Information Bulletin No. 209, Legislative Research Commission, Frankfort, 2003: 73.
- ¹⁶ "Roemer's Law," *Dartmouth Atlas of Health Care*, from *National Health Systems of the World*, Vol. 2 (Oxford University Press, 1993), online <http://www.dartmouthatlas.org/99USlinks/chap_3_roemer.php>.
- ¹⁷ Health Policy Development Branch (HPDB), Division of Epidemiology and Health Planning, 2002 *Kentucky Annual Hospital Utilization and Services Report* (Frankfort: Department for Public Health, 2003).
- ¹⁸ *Dartmouth Atlas of Health Care*, "Variations in the Use of Supply-Sensitive Services," 2003, online <www.dartmouthatlas.org>.
- ¹⁹ *Dartmouth Atlas*, "Variations."
- ²⁰ Elliott S. Fisher, David E. Wennberg, Thérèse A. Stukel, Daniel J. Gottlieb, F. L. Lucas, and Étoile L. Pinder, "The Implications of Regional Variations in Medicare Spending: Part I: The Content, Quality and Accessibility of Care," *Annals of Internal Medicine* 138.4 (2003): 273-287.
- ²¹ *Dartmouth Atlas*, "Variations."
- ²² *Dartmouth Atlas*, "Variations ... Kentucky's HRRs."
- ²³ *Dartmouth Atlas*, "Variations ... Kentucky's HRRs."
- ²⁴ HPDB, 2002 *Hospital Report*.
- ²⁵ Fisher et al., "The Implications of Regional Variations in Medicare Spending: Part II: Health Outcomes and Satisfaction with Care," *Annals of Internal Medicine* 138.4 (2003): 288-298.
- ²⁶ Laurence Baker, Howard Birnbaum, Jeffrey Geppert, David Mishol, and Erick Moynour, "The Relationship Between Technology Availability and Health Care Spending," *Health Affairs—Web Exclusive* 5 Nov. 2003.
- ²⁷ Baker et al.
- ²⁸ Baker et al.
- ²⁹ American Health Planning Association (AHPA), "2003 Relative Scope and Review Thresholds of CON Regulated Services," Table in *National Directory of Health Planning, Policy and Regulatory Agencies*, 14th edition (2003): 81-95.
- ³⁰ CSHSC, "Population Growth, Economic Downturn Stress Phoenix's Health Care Capacity," *Community Report*, Summer 2003.
- ³¹ CSHSC, "Premium Hikes and Malpractice Insurance Disrupt Miami Health Care Market," *Community Report*, Summer 2003.
- ³² Kelly J. Devers, Linda R. Brewster, and Paul B. Ginsburg, "Specialty Hospitals: Focused Factories or Cream Skimmers," (CSHSC) *Issue Brief* 62 (April 2003): 2.
- ³³ Hoangmai H. Pham, Kelly J. Devers, Jessica H. May, and Robert Berenson, "Financial Pressures Spur Physician Entrepreneurialism," *Health Affairs* 23.2 (2004): 70-81.
- ³⁴ Pham, Devers, May, and Berenson 73.
- ³⁵ Pham, Devers, May, and Berenson 80.
- ³⁶ Reed Abelson, "The Shifting Burden of Emergency Care," *The New York Times* 3 Feb. 2004, <www.nytimes.com> 3 Feb. 2004.
- ³⁷ General Accounting Office, *Specialty Hospitals: Geographic Location, Services Provided and Financial Performance* (Washington: GAO, Oct. 2003): 4.
- ³⁸ AHPA, *National Directory of Health Planning, Policy and Regulatory Agencies*, 13th edition (Falls Church, VA: AHPA, 2002): 80.
- ³⁹ Christopher J. Conover and Frank A. Sloan, "Does Removing Certificate-of-Need Regulations Lead to a Surge in Health Care Spending?" *Journal of Health Politics, Policy and Law* 23.3 (1998): 455-481.
- ⁴⁰ Conover and Sloan.
- ⁴¹ Report of the Ohio Director of Health, as cited by AHPA, in *Focus*, undated.
- ⁴² Gretchen McBeath, "Status Report on Ohio After Deregulation from Certificate of Need," Bricker and Eckler LLP, Columbus, Ohio, Sept. 2001, online <http://www.bricker.com/publications/articles/533.asp> 17 June 2003.
- ⁴³ McBeath.
- ⁴⁴ CSHSC, "Intense Competition and Rising Costs Dominate Cleveland's Health Care Market," *Community Report*, Winter 2003.
- ⁴⁵ Abelson.
- ⁴⁶ CSHSC, "Competition Revs Up the Indianapolis Health Care Market," *Community Report*, Winter 2003: 3.
- ⁴⁷ CSHSC, "Bitter Contract Dispute Reaffirms Blues' Dominant Position in Lansing," *Community Report*, Spring 2003.
- ⁴⁸ Thomas R. Piper, "Big-Three Automakers Health Care Costs non-CON vs. CON States," graph from DaimlerChrysler Corporation in presentation before planning panel for the Federal Trade Commission/Department of Justice Hearings on Health Care Competition, Quality, and Consumer Protection, 10 June 2003.
- ⁴⁹ AHPA, "2003 Relative Scope and Review Thresholds of CON Regulated Services," Table in *National Directory of Health Planning, Policy and Regulatory Agencies*, 14th edition (2003): 79.
- ⁵⁰ Piper, graph from Ford Motor Company.
- ⁵¹ Robert Pear, "Health Spending Rises to Record 15% of Economy," *The New York Times* 9 Jan. 2004.
- ⁵² Mary S. Vaughan-Sarrazin, Edward L. Hannan, Carol J. Gormley, and Gary E. Rosenthal, "Mortality in Medicare Beneficiaries Following Coronary Artery Bypass Graft Surgery in States With and Without Certificate of Need Regulation," *Journal of the American Medical Association (JAMA)* 288 (2002): 1859-1866.
- ⁵³ "The Slow-Me State," *Business and Health* 19.10 (2001): 14.
- ⁵⁴ Nancy Galvagni, Kentucky Hospital Association (KHA), interview, 2 April 2003.
- ⁵⁵ AHPA.
- ⁵⁶ John Gray, Director, Certificate of Need, interview, 24 Jan. 2003.
- ⁵⁷ Gideon Gil, "MRI Centers Open Without State OK," *The Courier-Journal* 1 Dec. 2003: B1.
- ⁵⁸ Midwest Diagnostic Centers of Louisville, Ltd., "Brief Summary of the Business Plan," 1 Dec. 2002: 1.
- ⁵⁹ CON records.
- ⁶⁰ HPDB, 2002 *Kentucky Annual Long-Term Care Services Report* (Frankfort: Kentucky Department for Public Health, Cabinet for Health Services, 2001): viii.
- ⁶¹ Wendy Fox-Grage and Robert Mollica, "Assisted Living," *Legisbrief* (National Conference of State Legislatures) 11.24 (2003).
- ⁶² HPDB, 2002 *Hospital Report* 117.
- ⁶³ HPDB, 2002 *Hospital Report* 104.
- ⁶⁴ HPDB, 2002 *Hospital Report* 117.
- ⁶⁵ HPDB, 2002 *Hospital Report* 117.
- ⁶⁶ HPDB, 2002 *Hospital Report* 117.
- ⁶⁷ Denise Grady, "Major Change in Mental Health Care Is Urged," *The New York Times* 23 July 2003, online <www.nytimes.com> 23 July 2003.
- ⁶⁸ American Heart Association, "Emergency Angioplasty OK Without Surgical Back-up," meeting report from AHPA's Scientific Sessions 2002, 17 Nov. 2002.
- ⁶⁹ "KHA Proposed Pilot Project: Primary Angioplasty," and "KHA Pilot Project for Primary Angioplasty Requirements for Emergency Cardiac Backup; State Oversight," KHA, 2004.
- ⁷⁰ Kenneth Thorpe, "Inbox," *Hospitals & Health Networks*, Aug. 2002 <www.hhnmag.com>, 1 March 2003.
- ⁷¹ Jerry H. Gurwitz, Terry S. Field, Leslie R. Harrold, Jeffrey Rothschild, Kristin Debellis, Andrew C. Seger, Cynthia Cadoret, Leslie S. Fish, Lawrence Garber, Michael Kelleher, and David W. Bates, "Incidence and Preventability of Adverse Drug Effects Among Older Persons in the Ambulatory Setting," *JAMA* 289.9 (2003): 1107-1116.
- ⁷² R. Kaushal, D.W. Bates, C. Landigran et al., "Medication Errors and Adverse Drug Effects in Pediatric Inpatients," *JAMA* 285.16 (2001): 2114-2020.
- ⁷³ Chunliu Zhan and Marlene R. Miller, "Excess Length of Stay, Charges, and Mortality Attributable to Medical Injuries During Hospitalization," *JAMA* 290.14 (2003): 1868-1874.
- ⁷⁴ The Leapfrog Group, "About Us," <http://www.leapfroggroup.org/about.htm> 4 Feb. 2004.
- ⁷⁵ Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century* (Washington: National Academies of Science, 2001); full text available online at: <http://www.nap.edu/books/0309072808/html/>.

Scanning Kentucky

Emerging trends and issues that may affect the Commonwealth's future

Stubborn Core Issues Continue to Dog States

Higher Education Costs, Scrutiny Rise

Changing workforce needs and economic conditions continue to drive strong demand for educated workers, but the United States has fallen from 1st to 13th among developed nations in college participation leading to a bachelor's degree in the last decade, according to the Education Commission of the States (ECS). Over the next decade, ECS predicts, half the states likely will see little or no growth or an actual decline in their numbers of traditional college-age enrollments. Already, nontraditional students, adults aged 25 and older, comprise nearly half of the more than 17 million students enrolled in U.S. colleges.

For now, rising demand and declining government support for public colleges are forcing the costs to students ever higher. The nation's public universities, community colleges, and private universities raised 2003-2004 tuition by 14 percent on average, the highest increase in more than a quarter a century, according to the College Board. Over the last two decades, the burden of paying for public colleges has gradually shifted from state government to students. At the same time, private colleges upped tuition by 6 percent, the third year in a row they had opted for increases of 5 percent or more, twice the rate of inflation. Regardless of where students opt to attend college, these tuition hikes have come during times when many students and their families can least afford them.

Congress has not missed the import of rising tuition. In the House where lawmakers are overseeing reauthorization of the Higher Education Act, a pending bill would withhold federal money from colleges that raised tuition much faster than inflation, a category which includes hundreds of universities. The reauthorization process could also include a look at gaps in financial aid and disparities dating from the 1970s that channel more federal dollars to the nation's richest schools. Under current policy, when low-income students get money from the federal Pell grant program, the college receives funds as well. For every Pell dollar one of its students received in the 2000-2001 academic year, the median college got an extra 7 cents. Harvard University, however, got 98 cents while MIT got \$1.09 and Princeton got \$1.42. At the other end of the scale sit institutions like City University of New York which had the most financial aid applicants in the nation that year but got only 4 cents on the dollar. More than 50 colleges got just a penny per low-income student.

High earnings by university presidents, *The Chronicle of Higher Education* reported in November 2003, may be contributing to fiscal pressures on campuses. Four presidents of private universities

were paid more than \$800,000 in 2002. At all the highest-paying universities, presidential compensation has increased at least twice as much as faculty pay over the last five years. Public universities tend to pay their presidents substantially less than private universities, but according to a 2003 survey, 12 public university presidents—twice as many as in 2002—were paid more than \$500,000. With many states raising tuition and slashing their budgets for higher education, legislators are showing increasing discomfort about salary trends for college presidents.

The present financial aid process does little to smooth the way for would-be college students, one study finds. Typically, high-achieving students can expect to receive individualized packages of loans, grants, and work opportunities from each school where they apply. When researchers at the National Bureau of Economic Research followed a group of these students, they found that some did not make rational choices. Many were influenced by marketing and the tactic of “frontloading,” generous offers of aid that dwindle away as the student's academic career progresses. In short,

these researchers concluded, many students lacked the sophistication to evaluate loan and work-study programs versus grants. Parents had their own complaints in responses to surveys about the aid process which many reported finding “bewildering” and “confusing.”

One public institution of higher education has laid the issue of access for low-income students to rest. The University of North Carolina at Chapel Hill announced in October that it would cover the full cost of an education for

students from families of the working poor without forcing the students to take on loans. It's believed to be a first for a public college, the majority of which ratcheted up tuition last year as higher education outlays declined.

Taking a radically different approach, three top Virginia colleges reportedly plan to ask their General Assembly to grant them more autonomy, so they can determine their own financial destiny and rely less on state funding. Some South Carolina schools also reportedly are taking a hard look at taking only private funds. Critics see this movement as a dangerous movement toward the privatization of higher education and its dependence upon corporations for support.

Quality is getting one higher education leader's attention. Dr. John Sexton, President of New York University, has taken up the issue of who teaches undergraduates. Dr. Sexton is determined to increase the attention undergraduates get by pressing tenured professors to spend more time with undergraduates and creating new categories of faculty members. The idea would be to supplement



tenured faculty not with adjunct teachers who are hired as part-time workers but with higher-prestige professors willing to teach without tenure. This would add luster to the school without the cost of professors tenured for life.

Implications for Kentucky. Realization of the Commonwealth's long-term goals for a more educated populace depend upon the continued entry of traditional and nontraditional students into public and private colleges here. Data from the ECS suggest the state will be going against the tide for enrollments to grow. Certainly, given the anemic growth of the state's youth population, the entry and persistence of more nontraditional students will continue to play a key role in raising the state's education profile relative to other states equally intent on future success.

Finally, as the demand for and cost of higher education escalates, so too will the public pressure on both lawmakers and higher education leaders. Their challenge in regard to these institutions, which are still heavily supplemented by the public sector, will be to do more with less, to respond to citizens who need the education, skills, and credentials they offer.

Health Care Conundrum Deepens



Health care spending reached a new peak as the year began: it now accounts for nearly 15 percent of the nation's economy, the largest share on record, up 9.3 percent in 2002 to \$1.55 trillion, *The New York Times* reported in early 2004. The growth has been fueled largely by spending for increasingly costly hospital care, which most analysts attribute to widespread labor shortage, and prescription drugs. Data from the Center for Studying Health System Change

for the first half of 2003, however, suggest that health care spending has leveled off but at an uncomfortable 8.5 percent rate of increase, sharply higher than the modest increases of the mid-1990s.

Employers have slowed runaway health care costs more than expected this year, but mostly by shifting an unprecedented share of the expense to employees. *The Wall Street Journal* reports that those in employer-sponsored health plans are paying 48 percent more out of their own pockets for care than they did just three years ago, and employer surveys suggest the cost will be even higher next year. People who use medical services most heavily are paying higher copayments and deductibles, while premiums for family plans have soared. Some new plans give workers a fixed sum to spend.

In addition to cost worries, the lack of health insurance, a problem once confined mostly to the poor and nearly poor, has edged into the lower middle classes, most notably to those earning \$25,000 to \$49,999 a year, and even to some above \$50,000, according to an analysis by *The New York Times*. As a result, health care costs and access now resonate with more people and are likely to remain atop the political agenda for the foreseeable future.

While many Americans have lost their employer-sponsored health benefits to layoffs, the number of people retiring with health insurance from their employers has dropped significantly since 1996, leaving many recent retirees without coverage for costly prescription drugs. As reported in *Health Affairs*, these findings underscore both the need for a Medicare drug benefit and the importance of structuring that benefit in such a way that it will preserve employer-sponsored coverage.

Not surprisingly, dissatisfaction with the current health care system has reached such high levels that an estimated 49 percent of U.S. physicians support legislation to establish national health insurance, according to survey findings reported in the medical journal, *Annals of Internal Medicine*. Forty percent of physicians said they would oppose the legislation. Among those physicians who endorsed national health insurance, 61 percent supported a single-payer federal system.

With only three states showing a budget surplus, all 50 governors lined up in a rare show of support for a provision of the House prescription drug bill that would shift as much as \$7 billion in costs to the federal government to cover more than 6 million people known as "dual eligibles," people who qualify for prescription coverage under both federally funded Medicare and Medicaid, the federal-state partnership for the poor.

Not willing to wait for federal remedy to solve problems at home, Maine may be on its way to being the first state to offer its citizens universal health care, according to *Governing*. Relatively new legislation, championed by Gov. John Baldacci, who made it the centerpiece of his campaign, addresses three major health care issues: access to care, cost containment, and quality of care.

Implications for Kentucky. Cost, access, and the quality of health care, which relates to both cost and access, have proven to be perennial public policy concerns. Only the specter of terrorism and war have displaced public anxiety about health care costs and accessibility in the United States. In spite of public pressure, comprehensive strategies for change have remained in short supply. Continued slow job growth has worsened the situation, curtailing revenues that might finance remedies at the state and federal level and increasing the number of citizens of all ages who need help with meeting the cost of health care. Maine's ambitious program for closing gaps is the noteworthy exception, as many cash-strapped states are finding ways of reducing Medicaid rolls, rather than looking for cost-efficient ways of expanding the program.

Even the recently passed expansion of Medicare to provide prescription drug coverage, which will not go into effect until 2006, offers states little promise of fiscal relief from the burden of Medicaid costs. Under the new law, states will be required to shoulder varying portions of the cost of "dual eligible" coverage for current Medicaid recipients. Payments or so-called "clawbacks" to the federal government will be based on a complex formula linked to 2003 per capita dual eligible Medicaid expenditures for drugs, trends in these costs, and the number of eligible seniors. Many seniors, some analysts conclude, will lose benefits if state prescription drug programs are permitted to lapse. Moreover, any unmet needs under the new "Part D" Medicare benefit for today's low-income, dually eligible seniors will be left to states to cover in full should they opt to respond to the plight of poor seniors.

Federal and State Budgets Still Reeling

The \$44 trillion federal deficit has the potential to bankrupt the government as public need approaches a historic peak, a *Fortune* magazine analysis concludes. As a growing portion of the U.S. population ages, retires, and becomes at least partly dependent upon government programs like sacrosanct Social Security and Medicare, they will almost certainly add new fiscal pressures to federal budgets. But fewer workers now support the programs on which retirees rely, and the ratio of worker to retiree is expected to become even smaller as the full force of the Baby Boomer generation

moves into retirement and begins to collect its promised benefits. At the same time, the out-of-pocket health care costs that current workers—and retirees—are shouldering are spiking upward, putting added strain on worker wages and retiree pensions.

In spite of the promising economic signs that have heralded an impending economic turnaround, state budgets continue to be stressed by slow job growth and rapidly rising health care costs, *The New York Times* reports. Battles in state capitals over taxing and spending are expected to rage throughout the foreseeable future. So far, states have responded with fiscal retrenchment. On average, state spending has tapered off sharply, rising by only half a percent annually over the past three years, compared with an average increase of 6.5 percent a year over the preceding quarter century. But many warn that states have already cut the fat from their budgets. Next on the chopping block could be the lean muscle that supports future growth: elementary and secondary education.

During the past three years, state leaders have staved off a cumulative \$200 billion debt by making huge budget cuts, raising taxes and fees, and finding creative one-time remedies to forestall having to increase taxes. From borrowing against tobacco monies, which are looking less and less like a certain long-term source of revenue, to a successful California referendum that makes way for the state to borrow billions to meet its mounting debt, to a defeated Alabama proposal for moderniz-

ing an antiquated tax structure, states are struggling with costly obligations, slow employment growth, and, in turn, anemic revenue gains.

The massive shortfalls led *Governing* commentator, David Brunori, to propose one response to stalled revenue growth. Brunori argues that states should “end the practice of granting tax incentives to individual corporations as a means of fostering economic development.” Corporations, he argues, have essentially played the system, pitting states against one another to avoid taxation.

Hungry for revenue, *Governing* reports that states are looking at ways of collecting the taxes already on their books. So far, 20 states have passed laws aimed at harmonizing their sales tax laws with each other, with an eye toward taxing Internet-based and catalogue sales. Both are generally subject to taxation but such purchases are seldom reported. With all states on board with the Streamlined Sales and Use Tax Agreements, online and catalogue retailers could be held responsible for collecting the appropriate state taxes from the buyer.

Implications for Kentucky. Nowhere is the struggle to close nagging budget shortfall, to contain health care and higher education costs, to modernize a tax structure that is no longer adequate to the task of shouldering demands on state government, all while preserving the shared goal of rising, broad-based prosperity, more evident than here in the Commonwealth.



FOR ESIGHT

111 St. James Court
Frankfort, Kentucky 40601-8486
Phone: 502-564-2851 or 800-853-2851
Fax: 502-564-1412 or 800-383-1412
E-Mail: info@kltprc.net
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